Small Group Home Projects for the Elderly

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Care in small group homes is one service that can help older individuals remain in the community. This service was born out of the inability of the foster care program for the elderly to expand sufficiently to meet the demands for protective shelter.

In many communities the aged person is often placed in an institution because there is no other way to provide protection or needed services to the individual. This method of care is costly both to the community in terms of money, and to the individual who may have to sacrifice his individuality and autonomy. A community which offers a broad spectrum of services to the aged can do much to prevent early institutionalization, as well as providing some alternatives to the total institution.

Care in small group homes is one service that can help older individuals remain in the community. This service was born out of the inability of the foster care program for the elderly to expand sufficiently to meet the demands for protective shelter. Foster care for the elderly is a difficult program to institute. It is hard to recruit suitable homes; it is hard for families to accept this service; and only a selected group of people are suitable for it. Fitting an elderly person into a household is almost like arranging a marriage and requires similar careful selection since the resident and home owner are dependent upon each other for emotional gratification. The usual type of person most likely to adjust to foster care is one with good ego strengths who can maintain good personal relationships, and enjoy family life. Experience has shown that a withdrawn person, or one who does not care to, or cannot relate to family roles will be a poor candidate for such a setting.

At the beginning of the foster home program, it was assumed that the older person would be integrated into the foster home and thus become a kind of family member. Homes were recruited on this basis. While many elderly people enjoyed this kind of setting, many appeared to make a poor adjustment. It is sometimes hard for children with elderly parents to accept this program. They find it difficult to tolerate having a strange family care for their parent when they themselves are unable or unwilling to do so. It also has become increasingly difficult to recruit homeowners who are willing to commit themselves emotionally to the care of the elderly.

Along with these difficulties, the growth of the elderly population increased the demand for some form of sheltered housing. As a result, we encouraged the home owners we had already recruited to increase their capacity. We began to place two to three elderly in one home, the number depending upon the bedroom space available. The home owners welcomed this arrangement since it made the service more rewarding financially. Most families take in elderly people because they need to supplement their income. We found this to be a good motivation. If the home owner views himself as running a business, there is less chance of neurotic needs being worked out on vulnerable elderly. The home owners are screened, of course, to eliminate those who are more interested in money

than in people. There is little profit to be made from foster care, but it does allow enough profit so that a widow can pay her rent and eat decently. It also allows the widow to feel useful.

In evaluating our first few experiences with small group living arrangements, we found that most of the elderly enjoy this arrangement. It affords them more opportunity for companionship, and it allows them a choice of roles; they give each other mutual support; and the group medium allows for a larger variety of inter-relationships, both positive and negative. It became apparent that older people have less need for a two-parent type of family arrangement. Most elderly people have well established life patterns and do not need or usually want the kind of nurturing that young people need. As adults, they are by and large capable of making their own decisions. The aged have no need for parental models to emulate! This psychological consideration supported also by practical needs resulted in the introduction of the one-parent family for foster care. Thus we were able to recruit widows, widowers and single persons who were interested in opening their homes to the elderly.

This agency has a small group of people, mainly widows, who have taken into their own homes small groups of elderly. These homes are small enough to offer a personalized service to each individual. They offer a setting which can accommodate eccentric behavior. They even can tolerate persons who have difficult personality problems. They are more structured and offer more protection than does living alone in an apartment. They offer a choice of menu and can program recreation and other services more effectively. They offer some of the advantages of institutional life without the disadvantages of mass living with the attendant loss of autonomy.

The agency has continued to expand the number and variations of small group living arrangements. We rented and furnished a two-bedroom apartment in a two-family house. The two male residents prepare their own breakfast and lunch; and either eat dinner out or with the landlady downstairs. A domestic is provided for a few hours per week to keep the apartment clean and to do the laundry. This type of arrangement is suitable for well-adjusted healthy people who need security and some limited supportive services.

In another instance, we rented and furnished an apartment where three women live with help from a part-time homemaker who cooks and cleans. When the upstairs apartment became vacant, we leased it also. This two-family house now accommodates five people. The homemaker comes in for six hours per day to prepare lunch and dinner and to do the heavy cleaning. The homemaker acts as an enabler. She sees that the residents keep medical appointments, use recreational facilities and reports any problems to the caseworker. The residents care for themselves at night and during the weekend. This home accommodates three elderly ladies, a woman in her forties who is a functioning schizophrenic and a gentleman in his sixties who is also schizophrenic and sometimes is not fully in contact with reality. The women all pitch in to run the home and they enjoy mothering the gentleman who never looked better.

The agency also maintains two adjoining garden type apartments, one for three men and one for three women, with a live-in homemaker who takes care of both apartments. The residents of these apartments are more handicapped than those in our other apartments and need more care. The agency also runs a four bedroom house and has just opened another apartment for

men. We are continuing to expand this type of service which has become well accepted and successful. These homes are not licensed for domiciliary care, although they have been inspected by the Department of Health. In our larger homes, in addition to three elderly people, we have also placed younger retarded persons who are attending sheltered workshops or younger ex-mental patients who are working but who are too shaky emotionally to live by themselves. In this fashion we have been able to increase the occupancy rate of the homes legally without needing a license for domiciliary care. The mix of old and young is stimulating to both. The older people enjoy watching the young people grow, and the young people feel as if they truly have a family. The older people are usually between 75-80 years of age, and the younger ones are 40 to 50. The younger people are also more active in the physical care of the home and so less homemaker time is needed. This arrangement also has made it economically feasible for the agency to operate small group homes even when the client's only source of income may be SSI.

The selection of residents is very important to the success of a group home. The more handicapped client will need more protection; the healthy ones will be able to cope better and need less homemaker care. For example, our garden-type apartment has a live-in homemaker and we generally place our most vulnerable clients there. Currently, in the women's apartment, we have an aphasic woman, a senile woman and a retarded young woman. Because we feel these women would not be able to handle an emergency without help, we have 24 hour coverage seven days per week. It is possible to include in a group, one member who may need a bit more help if you know the other clients will make themselves available for this type of care. It often helps the healthier member feel important and useful.

In these small group settings the emphasis is placed on client cooperation and self-help. The resident must be ambulatory and be able to handle his own daily living routines. It is possible, however, to handle special diets and supervise oral medication to some degree. The only clients we have difficulty in placing are the blind and the incontinent.

While it is possible to operate an agency home at no cost to the agency except for staff salaries, it does require a broad spectrum of ancillary services.

Each client is assigned to an individual caseworker with whom he can discuss his individual problems and adjustment. In addition, a visiting caseworker is assigned to each home to run an in-house discussion group on a weekly basis. Here problems of daily living, menus, assignment of chores, etc., are discussed. The discussion group is also used to prepare for the entrance of a new member or discuss the moving of an old resident. In many instances, we can hold his room for a sick resident while he may be in the hospital, unless it is clear he will need a more protective setting. His friends will usually visit or call to assure him he will be welcomed back to the home.

The agency has a part-time public health nurse who checks on the health and medical follow-up of each client in every group unit. She advises the home-owner or homemaker on each client's diet, hygiene and sees that medication is administered properly.

The private home-owners meet regularly to discuss their problems. Separate meetings are held with homemakers running group homes because their problems are somewhat different. The private home-owners usually have a more handicapped clientele because they are available on a 24 hour basis.

Their relationship with the agency is different because they are in effect sub-contractors. The agency purchases care from them. They are expected to provide for full coverage of their home, and may take other private patients if they so desire.

The homemakers are salaried employees of the agency. The agency has full control of the placement of people and the quality of service rendered. The agency, however, carries the responsibility for planning for replacement of homemakers on vacation or sick leave.

Temporary illness is usually taken care of in the home. It has sometimes happened that more personal care may be needed for a client who may be awaiting a bed in either a hospital or nursing home. In such instances, we have been able to use a staff home health aide to give some bedside care.

Medical care is given by the client's own physician, or by the clinic. Transportation is arranged if necessary, to see that client's medical needs are met. The public health nurse often serves as a liaison with the physician if there are any questions about the client's health regime.

An attempt is made to see that all residents participate in social and community programs. All major Jewish holidays are celebrated. All residents are invited to a community Seder for Passover. Several homes may get together to celebrate Chanukah and other festivals. We have also encouraged our foster parents to devise their own program. We have had theater parties, picnics and other celebrations. In conjunction with the City Bureau of Recreation, an activity program has been arranged for the residents of our foster homes. Individuals also use the services of the Jewish Community Center freely. One of our foster parents manages a group of apartments and she types a newsletter as well as running an arts and crafts program for her residents.

Our group homes are also available on a limited basis for short periods of time so that a family can go on vacation and place a parent with us on a temporary basis. We have also used our service for short convalescent periods where no nursing care is required, such as recovery from a hernia repair or other minor surgery.

Who pays for all this? This program has no government support. The agency handles all financial details. In the situations in which we purchase care, we pay the home owner directly, and in turn, the client reimburses us. We have about 50-60 clients in care. About half pay full cost and the rest are subsidized by the agency. The client turns over his social security or pension check to the agency. He is given his personal allowance money for transportation and personal incidentals on a monthly basis. Clothing and other special items are given as needed.

The cost of operating an agency home can be computed by budgeting the rent, utilities, food and cost of homemaker service, offset by the payments of the residents. There is, of course, an initial cost of furnishing the apartment. We have been able to use donated furniture and appliances. Many of the residents are able to bring some of their own furniture, linen and dishes. Many of them bring their own T.V. and radios in addition to family pictures, etc. The budget should also include some money for replacement of linen and small appliances.

We have found that this type of small group home has become increasingly popular. The use of a homemaker has made the project more acceptable to some adult children. It also gives the agency more control over the quality of care in the home. It also allows the resi-

dents more autonomy, since he is allowed to participate in setting house rules.

This type of arrangement is not for the elderly who are very senile or ill and need a more protective setting. It is actually sheltered housing but in small scattered units. Because we rent apartments rather than building apartments, we can easily close an apartment, move to another neighborhood or open more apartments. This program proves very suitable in small communities or large cities alike.

This program has community acceptance. We have had no difficulty in renting apartments for this purpose. It is non-threatening to the adult children since they feel less guilty about placing their parents in this kind of setting. It appeals to the elderly because their needs are met unobtrusively and they can maintain a semblance of independence. Their participation in the running of the home helps them feel useful.

The program is, as yet, only a small part of the continuum of services necessary for our elderly, but an important one since it offers a valuable, innovative way for the elderly to remain in the community and participate in it with dignity and self-direction.

Trends in Jewish Child Care*

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In effect, then, a children's service today needs to be concerned with the child's total living and must therefore provide at each stage of his life the experiences and the services that are normal to that stage, as well as the treatment services for his problems. Children do not grow up on counseling or psychiatric treatment alone. Just as parents do, the agency must take a long time, longitudinal view of the child's growth . . .

THIS article results from an assignment given the author to report on trends in Jewish child care.

In the absence of reliable published statistics and other information about needs, types and volumes of service in Jewish agencies, the writer sent a questionnaire to eight large children's and merged family and children's agencies inquiring about recent developments in children's services. The agencies in descending order of Jewish population size were Jewish Child Care Association of New York, Vista Del Mar of Los Angeles, Association for Jewish Children of Philadelphia, Jewish Children's Bureau of Chicago, Jewish Family and Children's Service of Boston, Jewish Family and Children's Service of Baltimore, Jewish Children's Bureau of Cleveland and Jewish Family and Children's Service of Detroit.

Replies to the Questionnaires

The first question was intended to obtain facts about the problems found in the families and children who come to our agencies today.

Have You Seen Any Changes in the Past Few Years in the Nature of the Family Problems That Come to Your Agency and in the Nature of the Problems That Children Present?

New York, Los Angeles, Philadelphia, Chicago and Cleveland report an increase in the unusually severe family and child problems, characterized among adults by emotional and mental illness and drug addiction, and among children by the severe character disorders exhibiting symptoms such as runaway, truancy, school failure, and bizarre behavior including drug use and sexual activity at a younger age (homosexual as well as heterosexual). These agencies observed that many more children who are referred for placement are seriously, often hopelessly disturbed. To quote Chicago, "When the request for placement comes, it is often after the children have been exposed to considerably more trauma during efforts to sustain the family in the community." Philadelphia notes that intake is flooded with poor and near poor parents who are so sick and disorganized as individuals and so utterly ineffectual in raising children from the earliest ages that the youngsters display gross deficits in physical care, emotional nurture, education and moral development. Cleveland cites an increase in the helplessness of parents in handling adolescents and an increase in serious disturbances among young children. New York and Philadelphia note an increasing number of children who display behavior symptomatic of brain damage.

New York attributes the increased child disturbance to recent changes in the delivery of mental health services, viz:

1. More out-patient clinical services are available in a community, and this

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